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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Outpatient Hospital Providers

HMOs and Other Managed Care Programs

Changes to Reimbursement and Program Requirements for Outpatient Hospital Therapy Services

Effective for dates of service on and after March 1, 2006, reimbursement rates and program requirements will change for outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services. The following changes will occur:

- Providers will be reimbursed up to an established maximum allowable fee.
- Providers will be required to follow program requirements for PT, OT, and SLP services (instead of program requirements for outpatient hospital services). Therefore, providers will be required to:
  - ✓ Submit claims using the CMS 1500 claim form or the 837 Health Care Claim: Professional transaction. The UB-92 claim form and 837 Health Care Claim: Institutional transaction will not be accepted when submitting claims for these services.
  - ✓ Follow prior authorization requirements and procedures for PT, OT, and SLP services.
  - ✓ Use *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes on claims submitted to Wisconsin Medicaid. Revenue codes will not be allowed when submitting claims for these services.

Beginning in December 2005, providers may access the new Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. In addition, outpatient hospital PT, OT, and SLP providers will receive the handbook on CD. The CD will be mailed in December 2005.

Changes for Outpatient Hospital Therapy Services

Effective for dates of service (DOS) on and after March 1, 2006, reimbursement rates and program requirements will change for outpatient hospital physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services.

Reimbursement

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, outpatient hospital PT, OT, and SLP services will no longer be reimbursed at a hospital-specific outpatient rate-per-visit. These services will be reimbursed up to an established maximum allowable fee. Providers should refer to Attachments 1, 2, and 3 of this *Wisconsin Medicaid and BadgerCare Update* for these rates. Maximum allowable fees are updated periodically. Providers will be notified when rates are updated.

Reimbursement Methods

Physical therapy, OT, and SLP services are reimbursed at the lesser of the billed amount or the maximum allowable fee. However, PT and OT services provided by physical therapist assistants (PTAs) and certified occupational therapy assistants (COTAs) when working under general supervision (after a supervision waiver is obtained) are reimbursed at the lesser of the billed amount or 90 percent of the maximum allowable fee.

Copayment Amounts

Copayment amounts for PT, OT, and SLP services are determined per procedure code and correspond to the maximum allowable fee for the procedure code. Refer to Attachments 1, 2, and 3 for copayment amounts. Refer to the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for information about the annual copayment maximum for PT, OT, and SLP services. Refer to the Recipient Eligibility section of the All-Provider Handbook for general information about collecting copayments and copayment exemptions.

Program Requirements

When providing outpatient hospital PT, OT, and SLP services, providers will be required to follow Medicaid requirements for PT, OT, and SLP services (instead of Medicaid requirements for outpatient hospital services). Outpatient hospital PT, OT, and SLP providers will no longer be subject to the rules and regulations under HFS 107.08, Wis. Admin. Code. Instead, these providers will be subject to the rules and regulations under HFS 107.16, 107.17, and 107.18, Wis. Admin. Code.

Providers should refer to the new Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for more information about topics included in this *Update* as well as all other topics related to PT, OT, and SLP services. Beginning in December 2005, providers may access the handbook on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. In addition, outpatient hospital PT, OT, and SLP providers will receive the handbook on CD. The CD will be mailed in December 2005.

Copayment amounts for PT, OT, and SLP services are determined per procedure code and correspond to the maximum allowable fee for the procedure code.

To receive Medicaid reimbursement for a covered service, all Medicaid requirements must be met. For PT, OT, and SLP services, the following must be true:

- Professional skills of a PT, OT, or SLP provider are required to meet the recipient's therapy treatment needs.
- Services are cost-effective when compared with other services that meet the recipient's needs.
- Services are established in a written plan of care (POC) before they are provided.
- Services are medically necessary as defined under HFS 101.03(96m), Wis. Admin. Code.
- Services are performed by a qualified provider and supervision requirements are met.
- Services are prescribed by a physician.
- Services are prior authorized by Wisconsin Medicaid, when applicable.

Providers

Outpatient hospital PT, OT, and SLP services refer to covered services provided by an approved hospital facility. Wisconsin Medicaid defines "hospital facility" as the physical entity, surveyed and approved by the Division of Disability and Elder Services, Bureau of Quality Assurance (BQA) under ch. 50, Wis. Stats. The BQA facility approval survey covers the building that the hospital identifies as constituting its operation.

Certification requirements remain unchanged for outpatient hospital PT, OT, and SLP providers. Wisconsin Medicaid requires

providers offering outpatient hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals to meet all Medicaid certification requirements but does not require them to be individually certified by Wisconsin Medicaid. The hospital is required to maintain records showing that its individual providers meet Medicaid requirements.

Effective immediately, Wisconsin Medicaid will begin accepting PA requests for outpatient hospital PT, OT, and SLP services to be provided on and after March 1, 2006.

Program requirements remain unchanged for providers offering off-site hospital PT, OT, and SLP services who are employed by, or under contract to, hospitals. These providers are required to be individually certified by Wisconsin Medicaid.

Services and Codes

Covered PT, OT, and SLP services are identified by the allowable *Current Procedural Terminology* and Healthcare Common Procedure Coding System procedure codes listed in Attachments 1, 2, and 3.

Modifiers are required when indicating certain PT, OT, and SLP services. Refer to the Codes chapter of the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for allowable modifiers.

Prior Authorization

Outpatient hospital PT, OT, and SLP providers will be required to follow prior authorization (PA) requirements and procedures for PT, OT, and SLP services. Effective immediately, Wisconsin Medicaid will begin accepting PA requests for outpatient hospital PT, OT, and SLP services to be provided on and after March 1, 2006.

Up to 35 DOS are allowed for each therapy discipline the first time a recipient requires PT, OT, or SLP services in his or her lifetime. This is called the recipient's *initial* spell of illness (SOI). The recipient's initial SOI does not require PA. However, some services always require PA, even when they are provided during a recipient's initial SOI. (Refer to the Requesting Extension of Therapy, Maintenance Therapy, and Services That Always Require Prior Authorization chapter of the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for information about services that always require PA.)

The initial SOI begins with the first day of evaluation or treatment and ends when the services are no longer required or after the 35 DOS, whichever comes first. The 35 DOS include any treatment days covered by other health insurance sources or any treatment days provided by another provider in any setting. If after 35 DOS a recipient's condition requires additional PT, OT, or SLP services, PA is required.

In most cases, PA must be obtained before providing the service. To obtain PA, a Prior Authorization Request Form (PA/RF), HCF 11018 (Rev. 10/03), must be submitted with the appropriate attachment to Wisconsin Medicaid. Outpatient hospitals have the following choices when submitting PA requests for PT, OT, and SLP services:

- The Prior Authorization/Therapy Attachment (PA/TA), HCF 11008 (Rev. 06/03).
- The Prior Authorization/Spell of Illness Attachment (PA/SOIA), HCF 11039 (Rev. 06/03).

Refer to the PA chapters of the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for more information about requesting PA and for copies of these forms.

Supervision Requirements

When supervision requirements are met, Medicaid reimbursement is available for

services provided by assistants, students, and aides who are qualified to provide the service. Physical therapists and occupational therapists who wish to use assistants under general supervision may receive a waiver granting an alternative to Wisconsin Medicaid's current supervision requirements for PTAs and COTAs. The waiver should be requested when a provider wishes to use assistants under general supervision as allowed by the supervision requirements of the Wisconsin Department of Regulation and Licensing.

To receive the waiver, each hospital is required to complete the Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements form, HCF 1149 (Rev. 07/00), only once. Effective immediately, Wisconsin Medicaid will begin accepting the form from outpatient hospitals. Refer to the Certification and Ongoing Responsibilities chapter of the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for more information about supervision requirements.

Documentation Requirements

As stated in HFS 106.02(9), Wis. Admin. Code, providers are required to prepare and maintain truthful, accurate, complete, legible, and concise medical documentation and financial records. Providers should refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for general information about documentation requirements.

To be reimbursed by Wisconsin Medicaid, all PT, OT, and SLP services must be documented in the recipient's medical record. Documentation requirements include, but are not limited to, the following:

- The physician's prescription for PT, OT, and SLP services.
- The written report of the recipient's evaluation.
- The recipient's POC.
- A written entry for each date a PT, OT, or SLP service is provided.
- Discharge plan, including any applicable home exercise programs and maintenance plans.

Prescriptions — To receive reimbursement for PT, OT, and SLP services, Wisconsin Medicaid requires a prescription. The prescription must be signed and dated by a physician and included in the recipient's medical record. The prescription is valid for one year or until a new POC is required.

Evaluations — Physical therapy, OT, or SLP providers are required to include a written report of the recipient's evaluation in the recipient's medical record. The evaluation report must be signed and dated and include the following:

- Any test chart or form used in the evaluation.
- Assessment of the recipient's condition and recommendations for therapy intervention.
- Baseline measurements that establish a performance or ability level using units of objective measurement that can be consistently applied when reporting subsequent status of the recipient's progress.
- Chronological history of treatment provided for the diagnosis.
- Diagnosis(es) with date(s) of onset, current medical status, and functional status of the recipient.
- Functional limitations related to an identified deficit.
- List of other PT, OT, and SLP service providers who are currently treating the recipient to the extent known by the evaluating PT, OT, or SLP provider.

To receive the waiver, each hospital is required to complete the Request for Waiver of Physical Therapist Assistant and Occupational Therapy Assistant Supervision Requirements form, HCF 1149 (Rev. 07/00), only once.

- Previous level of function and change in medical status since previous PA requests if performing a re-evaluation.
- Reason for the referral.
- Underlying conditions or impairments to be treated.

In the event of a provider audit, auditors will review any or all of the provider and recipient records that support reimbursement for services provided on a specific DOS.

Plan of Care — Physical therapy, OT, or SLP providers are required to establish a written POC for all recipients before providing services. The POC must be promptly signed and dated by the prescribing physician and included in the recipient's medical record. The POC must include the following:

- Diagnoses.
- Amount, frequency, duration, and specific PT, OT, or SLP services.
- Reports of current status that support the POC.
- Measurable objectives.
- Anticipated short- and long-term functional goals, which must be outcome based, appropriate for the diagnoses or presenting problems, and related to the specific PT, OT, and SLP services.
- A reasonable estimate of when the goals will be achieved.
- Communication and coordination with other providers. Such documentation includes the following:
  - ✓ Date(s) of communication.
  - ✓ Person(s) contacted.
  - ✓ A brief summary of the PT, OT, and SLP services provided by the other providers.
  - ✓ The unique and specific contribution of this PT, OT, or SLP provider given other PT, OT, and SLP providers' contributions.

At least every 90 days, or earlier if necessary, both of the following must occur:

- Physical therapy, OT, and SLP providers are required to do one of the following:
  - ✓ Develop a new POC.
  - ✓ Review and update the POC.
- Physicians are required to sign and date the POC with each review.

Daily Entries — Physical therapy, OT, and SLP providers are required to write a note in the recipient's medical record for every DOS. In the event of a provider audit, auditors will review any or all of the provider and recipient records that support reimbursement for services provided on a specific DOS. Records limited to checklists with attendance, procedure codes, and units of time are insufficient to meet this requirement. Daily entries must include the following:

- Date of service.
- Duration of the PT, OT, or SLP session.
- Specific treatment activities/interventions provided and the corresponding procedure codes.
- Problem(s) treated.
- Objective measurement of the recipient's response to the services provided during the treatment session.
- Signatures and credentials of the performing provider and, when necessary, the appropriate supervising therapist.

If a PT, OT, or SLP session does not occur as scheduled, the provider is required to indicate the reason the session did not occur.

Claims

Providers will be required to submit claims using the CMS 1500 claim form or the 837 Health Care Claim: Professional (837P) transaction for outpatient hospital PT, OT, and SLP services. When submitting these claims, the billing provider number of the hospital must be indicated. (A performing provider number

should not be indicated on the claim.) Refer to the Claims chapter of the Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Handbook for more information about submitting claims.

Medicaid reimbursement remains unchanged for crossover claims (i.e., claims for services allowed by Medicare when provided to dual eligibles and Qualified Medicare Beneficiary-Only recipients). When submitting crossover claims (i.e., automatic crossover claims, provider-submitted crossover claims) for outpatient hospital PT, OT, and SLP services, providers should continue following Medicare's procedures.

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by Wisconsin Medicaid, the provider may submit a claim for those services directly to Wisconsin Medicaid. These claims should be submitted using the CMS 1500 claim form or the 837P transaction. To allow payment by Wisconsin Medicaid in this situation, providers are encouraged to follow Medicaid requirements (e.g., request PA before providing the service for Medicaid-covered services that require PA). If Medicaid requirements are followed, Wisconsin Medicaid may reimburse for the service up to the Medicaid-allowed amount (less any payments made by other health insurance sources).

For More Information

Outpatient hospital PT, OT, and SLP providers with questions about this *Update* may submit their questions to *therapyquestions@dhfs.state.wi.us*. Providers may also call Provider Services at (800) 947-9627 or (608) 221-9883.

Training Sessions

Outpatient hospital PT, OT, and SLP providers should receive invitations to training sessions. Providers who have not received invitations should refer to the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for information about the training sessions.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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ATTACHMENT 1
Allowable Procedure Codes for Outpatient Physical Therapy Services
(Effective for Dates of Service on and After March 1, 2006)

Evaluations					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
97001	Physical therapy evaluation [15 minutes]	Not applicable	No	$1	$18.13
97002	Physical therapy re-evaluation [15 minutes]	2 per day	No	$1	$13.56

Modalities					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care	1 per day	Yes	$1	$22.16
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	1 per day	Yes	$1	$22.16
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	1 per day	Yes	$1	$22.16
90901	Biofeedback training by any modality [15 minutes]	Not applicable	Yes	$2	$46.12
97012	Application of a modality to one or more areas; traction, mechanical	1 per day	Yes	$2	$25.52
97016	vasopneumatic devices	1 per day	Yes	$1	$24.94
97018	paraffin bath	1 per day	Yes	$1	$18.75
97020	microwave	1 per day	Yes	$1	$18.31
97022	whirlpool	1 per day	Yes	$2	$25.52
97024	diathermy	1 per day	Yes	$1	$18.85
97026	infrared	1 per day	Yes	$1	$17.74
97028	ultraviolet	1 per day	Yes	$1	$22.16

Modalities (Continued)					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes	$1	$22.16
97033	iontophoresis, each 15 minutes	Not applicable	Yes	$1	$23.28
97034	contrast baths, each 15 minutes	Not applicable	Yes	$1	$15.77
97035	ultrasound, each 15 minutes	Not applicable	Yes	$1	$18.31
97036	Hubbard tank, each 15 minutes	Not applicable	Yes	$2	$34.85
97039	Unlisted modality (specify type and time if constant attendance)	1 per day	Yes	$2	$31.05

Therapeutic Procedures					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes	$2	$29.59
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes	$2	$29.10
97113	aquatic therapy with therapeutic exercises	Not applicable	Yes	$2	$36.59
97116	gait training (includes stair climbing)	Not applicable	Yes	$2	$28.83
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes	$1	$23.18
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes	$1	$19.24
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	Not applicable	When appropriate*	$2	$25.28
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	Not applicable	Yes	$1	$17.51
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes	$2	$31.06

Therapeutic Procedures (Continued)					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes	$1	$18.68
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	Not applicable	Yes	$1	$20.72
97542	Wheelchair management/propulsion training, each 15 minutes	Not applicable	Yes	$1	$18.75
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters	1 per day	No	$2	$41.93
97598	total wound(s) surface area greater than 20 square centimeters	1 per day	No	$3	$53.53

Other Procedures					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Physical Therapist Assistant**	**Copayment**	**Maximum Allowable Fee**
93797	Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	1 per day	No	$2	$27.72
93798	with continuous ECG monitoring (per session)	1 per day	No	$2	$43.79
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation	1 per day	No	$1	$16.64
94668	subsequent	1 per day	No	$1	$10.25

*When provided by physical therapist assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal).

Notes: Procedure codes for many physical therapy (PT) services are defined as 15 minutes. One unit of these codes = 15 minutes. If less than 15 minutes is used, bill in decimals. For example, 7.5 minutes = .5 units.

All other procedure codes for PT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

ATTACHMENT 2
Allowable Procedure Codes for Outpatient Occupational Therapy Services
(Effective for Dates of Service on and After March 1, 2006)

Evaluations					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**	**Copayment**	**Maximum Allowable Fee**
97003	Occupational therapy evaluation [15 minutes]	Not applicable	No	$1	$18.13
97004	Occupational therapy re-evaluation [15 minutes]	2 per day	No	$1	$13.56

Therapeutic Procedures					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**	**Copayment**	**Maximum Allowable Fee**
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not applicable	Yes	$2	$29.59
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Not applicable	Yes	$2	$29.10
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not applicable	Yes	$1	$23.18
97139	Unlisted therapeutic procedure (specify)	Not applicable	Yes	$1	$19.24
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	Not applicable	When appropriate*	$2	$25.28
97150	Therapeutic procedure(s), group (2 or more individuals) [each 15 minutes]	Not applicable	Yes	$.50	$6.02
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	Not applicable	Yes	$1	$17.51

Therapeutic Procedures (Continued)					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**	**Copayment**	**Maximum Allowable Fee**
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Not applicable	Yes	$2	$31.06
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes	$1	$17.19
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Not applicable	Yes	$1	$18.68
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	Not applicable	Yes	$1	$20.72
97542	Wheelchair management/propulsion training, each 15 minutes	Not applicable	Yes	$1	$18.75
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters	1 per day	No	$2	$41.93
97598	total wound(s) surface area greater than 20 square centimeters	1 per day	No	$3	$53.53

Modalities					
Procedure Code	**Description**	**Limit Per Day**	**Service May Be Provided by a Certified Occupational Therapy Assistant**	**Copayment**	**Maximum Allowable Fees**
90901	Biofeedback training by any modality [15 minutes]	Not applicable	Yes	$2	$46.12
97016	Application of modality to one or more areas; vasopneumatic devices	1 per day	Yes	$1	$24.94
97018	paraffin bath	1 per day	Yes	$1	$18.75
97022	whirlpool	1 per day	Yes	$2	$25.52
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	Not applicable	Yes	$1	$22.16
97033	iontophoresis, each 15 minutes	Not applicable	Yes	$1	$23.28
97034	contrast baths, each 15 minutes	Not applicable	Yes	$1	$15.77
97035	ultrasound, each 15 minutes	Not applicable	Yes	$1	$18.31

* When provided by certified occupational therapy assistants, Medicaid reimbursement is not available for myofascial release/soft tissue mobilization for one or more regions or joint mobilization for one or more areas (peripheral or spinal).

Notes: Procedure codes for many occupational therapy (OT) services are defined as 15 minutes. One unit of these codes = 15 minutes. If less than 15 minutes is used, bill in decimals. For example, 7.5 minutes = .5 units.

All other procedure codes for OT services do not have a time increment indicated in their description. For these procedure codes, a quantity of "1" indicates a complete service.

ATTACHMENT 3
Allowable Procedure Codes for Oupatient Speech and Language Pathology Services
(Effective for Dates of Service on and After March 1, 2006)

Procedure Code	Description	Billing Limitations	Additional Conditions	Copayment	Maximum Allowable Fee
31575	Laryngoscopy, flexible fiberoptic; diagnostic		Use this code if speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610, as appropriate. For treatment, use 92507 or 92526, as appropriate. This service is to be performed according to the American Speech-Language-Hearing Association (ASHA) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.	$3	$74.51
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy		Use this code if speech-language pathologist actually inserts a laryngoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the laryngoscope; instead, use code 92506 or 92610 as appropriate. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.	$3	$119.62
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	Cannot use on the same date of service (DOS) as 96105 or 92510.	This code is also used for re-evaluation.	$3	$60.04
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	Cannot use on the same DOS as 92510.	This code should be used for therapy services that address communication/cognitive impairments and voice prosthetics. If treatment focus is aural rehabilitation as a result of a cochlear implant, submit a prior authorization (PA) request using the Prior Authorization/Therapy Attachment (PA/TA), HCF 11008 (Rev. 06/03), to request code 92510.	$2	$47.44
92508	group, two or more individuals		Group is limited to two to four individuals.	$2	$28.01

Procedure Code	Description	Billing Limitations	Additional Conditions	Copayment	Maximum Allowable Fee
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	Cannot use on the same DOS as 92506 or 92507.	Prior authorization is always required. Use this procedure code for evaluation and treatment.	$3	$79.75
92511	Nasopharyngoscopy with endoscope (separate procedure)		Use this code if speech-language pathologist actually inserts an endoscope. Do not use this code if the speech-language pathologist is providing an analysis and does not insert the scope; instead, use code 92506 or 92610 as appropriate. Use this code for evaluation of dysphagia or assessment of velopharyngeal insufficiency or incompetence. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.	$2	$48.99
92512	Nasal function studies (eg, rhinomanometry)		Use this code if completing aerodynamic studies, oral pressure/nasal airflow, flow/flow studies, or pressure/pressure studies.	$2	$37.82
92520	Laryngeal function studies		Use this code for laryngeal air flow studies, subglottic air pressure studies, acoustic analysis, EGG (electroglottography) laryngeal resistance.	$2	$30.76
92526	Treatment of swallowing dysfunction and/or oral function for feeding		The recipient must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.	$2	$48.34
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient for the use of a voice prosthetic device (e.g., electrolarynx, tracheostomy-speaking valve). Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.	$3	$75.19

Procedure Code	Description	Billing Limitations	Additional Conditions	Copayment	Maximum Allowable Fee
92607*	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity. This can also be used for re-evaluations. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead, use code 92506.	$3	$62.97
92608**	each additional 30 minutes (List separately in addition to code for primary procedure)	This code can only be billed in conjunction with 92607.	A maximum of 90 minutes is allowable. The maximum allowable number of units for this service is one unit of 92607 and one unit of 92608.	$2	$31.48
92609	Therapeutic services for the use of speech-generating device, including programming and modification		This code describes the face-to-face services delivered to the patient to adapt the device to the patient and train him or her in its use.	$2	$47.17
92610	Evaluation of oral and pharyngeal swallowing function			$3	$71.51
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording		Accompanying a recipient to a swallow study is not reimbursable. This code involves participation and interpretation of results from the dynamic observation of the patient swallowing materials of various consistencies. It is observed fluoroscopically and typically recorded on video. The evaluation involves using the information to assess the patient's swallowing function and developing a treatment.	$3	$115.76
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording;			$3	$138.23

Procedure Code	Description	Billing Limitations	Additional Conditions	Copayment	Maximum Allowable Fee
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording;	Only allowable when used in conjunction with 92612.		$3	$129.34
92700	Unlisted otorhinolaryngological service or procedure		Prior authorization is always required to use this code. Use this code when no other *Current Procedural Terminology* code description appropriately describes the evaluation or treatment.	$3	Manually priced
96105***	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Cannot use on the same DOS as 92506, 92597, 92607, or 92608.		$2	$43.29

* The procedure code description defines this code as one hour. One unit of this code = 1 hour. If less than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units. If more than one hour of service is provided, up to one unit of code 92608 can be used in combination with this code.

** The procedure code description defines this code as 30 minutes. One unit of this code = 30 minutes. If less than 30 minutes is used, bill in decimals to the nearest quarter hour. For example, 15 minutes = .5 units.

*** The procedure code description defines this code as one hour. One unit of this code = 1 hour. A maximum of 90 minutes or 1.5 units is allowable. If less or more than one hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 units and 30 minutes = .5 units.

Notes: All codes listed in this chart, if billed with an applicable place of service code, are eligible for natural environment enhanced reimbursement.

As with Medicare, providers may not submit claims for services for less than eight minutes.

Most procedure codes for speech and language pathology services do not have a time increment indicated in their description. Except as noted above, a quantity of “1” indicates a complete service. The daily service limitation for these codes is one.